WASHINGTON STUDENT ACHIEVEMENT COUNCIL
EDUCATION · OPPORTUNITY · RESULTS

WASHINGTON STATE HEALTH PROFESSIONAL

LOAN REPAYMENT PROGRAM

Quarterly Service Verification Form

Do not leave blanks. Submit form **on or after** last day of quarter.

LOAN REPAYMENT RECIPIENT

2016 Quarter: ☐ Jan–Mar ☐ Apr–Jun ☐ Jul-Sep ☐ Oct-Dec

Name:

Address:

City: **State:** **Zip:**

Email:

Best Phone Number:

I certify that I am serving at the site listed on the right, and that I have fully applied funds received from the previous quarter to my educational debt.

Signature:_____

Date:_____

☐ *My remaining debt is less than my normal payment. Adjust final payment to payoff amount: $ _____*

☐ *I have no remaining eligible loan debt; my loans are paid in full. I realize that my payments will cease but I am not released from my remaining service obligation.*

DEFINITION OF

"FULL TIME EMPLOYMENT"

For all health professionals, *At least 32 hours of the minimum 40 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours at an approved & eligible site. The remaining 8 hours per week is/will be spent providing clinical services to patients, performing clinical support activities in alternate locations as directed by the site(s), or performing practice-related administrative activities.*

For part time, at least 20 hours of the minimum 24 hours per week are/will be spent providing direct outpatient care during normally scheduled clinic hours at an approved and eligible site as described above for full time employment.

Participants with a Federal (FSLRP) contract are only allowed a maximum of 35 days per contract year away from the clinic (July 1 – June 30) for any reason except FMLA. Participants with a State (HPLRP) contract are allowed a maximum of 40 days per contract year away from the clinic (July 1 – June 30) for any reason except FMLA.

PROGRAM INFORMATION

Form is due in our office no later than 14 days after the end of the quarter.
In January and July, you must submit payment history documentation.
Allow 14- 20 business days for payment to be processed.

EMPLOYER SECTION

Site Name:

Address:

City: **Zip:**

I have reviewed the hours worked and certify that the loan repayment recipient: *(check all that apply):*

Was employed at this site for the quarter indicated and **WORKED:**

☐ **Full time** - a minimum of 40 hours per week

☐ **Less than 40 hours per week, but a minimum of 24 hours per week – fill in box below.**

☐ **Actual Hours Worked this quarter.**
(Include all paid hours – do not include on-call or overtime hours)
Also use this box to fill in hours if submitting as the final form before the end of the quarter or if participant was on extended leave.

☐ Is/was on extended leave from _____ to _____ due to_____
Indicate the reason for the extended leave and record paid hours worked in the Actual Hours Worked - box above)

Paid Leave Hours: ____ Unpaid Leave Hours: ____

*See left column for maximum hours of leave per year allowed for **FSLRP** or **HPRLP** programs. FMLA recipients may arrange for a deferment by contacting program staff.*

The certifications and information provided above are true, accurate and complete to the best of my knowledge and belief. I have read and understand the definition of "full time" employment. I understand that I must retain the original copy of this form.

Signature:

Printed Name:

Title:

Date:

Phone Number:

Email:

The administrator (not the recipient) may mail, fax, or scan and email the service form to:
Mail: WSAC PO Box 4340 Olympia WA 98504-3430 **Fax:** 360-704-6242 **Email:** health@wsac.wa.gov **Phone:** 360-753-7794

REMEMBER FOR PAYMENT:** **It** ***is your responsibility to contact the Department of Enterprise Services (DES) to update any changes to your address, name or bank account information. Our office cannot make those changes for you.
Contact DES at: (360) 407-8180 or email ***payeehelpdesk@des.wa.gov***